Division of Health Service Regulation

	FOF DEFICIENCIES  OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED			
					R-C			
		FCL032105	B. WING		12/05/2014			
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE				
		713 EVA	STREET					
NUCARE	NUCARE FAMILY CARE HOME DURHAM, NC 27701							
(X4) ID PREFIX TAG			BE COMPLETE					
C 000	Initial Comments		C 000					
		sure Section conducted an survey on December 5,						
C 140	10A NCAC 13G .0405 Tuberculosis	5(a)(b) Test For	C 140					
	10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services. Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others.							
	failed to assure 2 of 2 employment received tuberculosis (TB) dise control measures add Health Services. The findings are:  1. Review of Staff A -Staff A was hired 10/ aide	ew and interview the facility Staff (Staff A, B) upon the 2nd step for ease in compliance with upted by the Commission for 's personnel file revealed: 15/2014 as a medication tation of a TB skin test						

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
	FCL 032105 B. WING			R-C		
		FCL032105	B. WING		12	2/05/2014
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
NUCARE	FAMILY CARE HOME		STREET M, NC 27701			
0(4) ID	STIWWADY ST	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF (	COPPECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 140	Continued From page	e 1	C 140			
	7/16/2014.	nentation of a 2nd TB skin				
	10:45am revealed: -Staff A had a TB skir read negative on 7/16 -Staff A was working first TB test was done -No second TB test hat the previous facility	at another facility when the e. ad been done when working				
	-Staff B had no docurr -Staff B had documer placed on 3/31/2014 4/1/2014.	B's personnel file revealed: mentation of a hire date. ntation of a TB skin test and read negative on mentation of a 2nd TB skin				
	10:50am revealed: -Staff B was hire not remember the exact date.	aff B, on 12/5/2014 at d in January, 2014 but could ne would have the 2nd TB				
	at 11:15am revealed: -Staff will ha immediately.	e Administrator on 12/5/2014  ve TB tests done  pe in order upon follow-up				

Division of Health Service Regulation

STATE FORM 6899 70Y511 If continuation sheet 2 of 5

Division of Health Service Regulation							
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		FCL032105	B. WING		R-C <b>12/05/2014</b>		
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE			
NUCARE	FAMILY CARE HOME	713 EVA DURHAN	STREET I, NC 27701				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE		
C 140	Continued From page	2	C 140				
ı	visit.						
C992	G.S. § 131D-45 G.S. § 131D-45. Examination and screening for		C992				
	G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes.						
	(a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or						
	physician shall includ substance, the presci	on. The verification from the e the name of the controlled ribed dosage and frequency, which the substance is					

Division of Health Service Regulation

prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior

examination and screening.

STATE FORM 6899 70Y511 If continuation sheet 3 of 5

Division of Health Service Regulation

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BL				CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		B. WING			R-C		
		FCL032105	B: Willo		12	2/05/2014	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE			
NUCARE	FAMILY CARE HOME	713 EVA	STREET 1, NC 27701				
	CUMMADVCT			DDOVIDEDIC DI ANI	OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
C992	Continued From page	e 3	C992				
	failed to assure scree substance upon hire	ew and interview, the facility					
	The findings are:  1. Review of Staff A's personnel file revealed: -Staff A was hired 10/15/2014 as a medication aide -Staff A had no documentation of a pre-employment drug screening.						
	10:45am revealed: -Staff A was not awar pre-employment drug						
	Interview with Sta 11:15am revealed: -Staff B was not awar pre-employment drug -Staff B stated she wascreening done imme	screening. ould have the drug					
	Interview with the	e Administrator on 12/5/2014					

Division of Health Service Regulation

STATE FORM 6899 70Y511 If continuation sheet 4 of 5

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SU COMPLET	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		R-C			
FCL032105		B. WING		12/05/2014				
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
NUCARE	NUCARE FAMILY CARE HOME 713 EVA STREET							
DURHAM, NC 27701  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID PROVIDE								
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE		
C992	Continued From page	e 4	C992					
C992	at 11:15am revealed: -Staff will ha immediately.		C992					

Division of Health Service Regulation

STATE FORM 6899 70Y511 If continuation sheet 5 of 5